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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11506

Registration District No. 4 Primary Registration District No. 3001 Registrar's No. 16

FILED FEB 3 1940

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(c) Name of hospital or institution: Rural Benton Tp.
(d) Length of stay: In hospital or institution 74 Years
In this community 74 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Adair
(c) City or town Kirksville
(d) Street No. Rural Benton Tp.
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME William Ogle
(b) If veteran, name war
(c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2 I4 I861
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 27-1940
year 3 ho minute M.
21. I hereby certify that I attended the deceased from Jan 30 to Feb 28 1940
that I last saw him alive on Feb 28 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months II Days I3
If less than one day hr. min.

Immediate cause of death: Pneumonia!
Due to Apoplexy
Due to

9. Birthplace Ohio
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

11. Industry or business
12. Name Lewis Ogle
13. Birthplace Choston Ohio
14. Maiden name Elzybeth Graves
15. Birthplace Choston Ohio
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant Bert Ogle.
(b) Address Kirksville Mo
17. (a) Burial (b) Date thereof I 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ownby Cemetary

23. Signature O. R. Martin (M. D. or other)
Address Kirksville Mo Date signed Feb 5

18. (a) Signature of funeral director
(b) Address Kirksville Mo-3
19. (a) 1-30-40 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Duration 3 days
3 da
PHYSICIAN Underline the cause to which death should be charged statistically.

522

RECEIVED

RECEIVED

District Health Officer No. 10

District File Number 2-40-205

Date Filed Jan. 30, 1940

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
HEALTH OFFICER'S REPORT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15-067
Do not use this space.

1. PLACE OF DEATH
 (a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. _____
 (c) City Kirkville (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Ogle
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (single the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>78</u>	<u>11</u>	<u>13</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Profound
apoplexy
 Other contributory causes of importance: 100

Date of onset _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) C. L. Marlin M. D. 0
 (Address) Kirkville mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

